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ABSTRACT

This study examined states' efforts to retain children in their State Children's Health Insurance Program (SCHIP). Data were obtained during spring and summer of 2000 through telephone interviews with state program officials from eight states selected based on a variety of demographic and programmatic variables; the states were Alabama, California, Colorado, Florida, Michigan, Missouri, New York, and North Carolina. The major findings include the following: (1) states' procedures for conducting SCHIP eligibility redetermination were quite similar to one another, but had not been simplified to the same level as initial enrollment processes; (2) less than half of enrolled children retained SCHIP eligibility at redetermination; (3) high rates of parents who do not respond to renewal notices nor submit renewal applications for their children may be cause for concern; (4) denial of eligibility for failure to pay premiums did not provide information on premium affordability because the denial code reflected several possible outcomes; and (5) state SCHIP and Medicaid data systems were highly variable in their capacity to report eligibility and redetermination outcome data. Implications of findings for future policy include the need to simplify eligibility redetermination procedures, to monitor the dynamics of families with children enrolled in SCHIP, to make renewal notices more user-friendly, and to improve states' administrative data systems. It was concluded that if states are to make informed improvements in their eligibility renewal policies, they need either to invest in improving administrative data systems, or to periodically conduct research to understand better what happens to children once they lose their

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SCHIP eligibility. (Contains 11 endnotes and 9 references.) (KB)

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Is There a Hole in the Bucket?
Understanding SCHIP Retention

Ian Hill
Amy Westpfahl Lutzky

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Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

SCHIP
State Children's Health Insurance Program Evaluation

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Understanding SCHIP Retention

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SCHIP
State Children's Health Insurance Program Evaluation

Assessing the New Federalism
An Urban Institute Program to Assess Changing Social Policies

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This report is part of the Urban Institute's *Assessing the New Federalism* project, a multiyear effort to monitor and assess the devolution of social programs from the federal to the state and local levels. Alan Weil is the project director. The project analyzes changes in income support, social services, and health programs. In collaboration with Child Trends, the project studies child and family well-being.

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About the Series

Assessing the New Federalism is a multiyear Urban Institute project designed to analyze the devolution of responsibility for social programs from the federal government to the states, focusing primarily on health care, income security, employment and training programs, and social services. Researchers monitor program changes and fiscal developments. In collaboration with Child Trends, the project studies changes in family well-being. The project aims to provide timely, nonpartisan information to inform public debate and to help state and local decisionmakers carry out their new responsibilities more effectively.

Key components of the project include a household survey, studies of policies in 13 states, and a database with information on all states and the District of Columbia, available at the Urban Institute's web site. This paper is one in a series of occasional papers analyzing information from these and other sources.

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Foreword

This is one of a series of reports exploring policy issues that have emerged during states' early implementation of the State Children's Health Insurance Program, or SCHIP. These reports seek to identify important challenges states have faced, explore the availability of data to analyze these issues, provide initial analysis of the effects of alternative policies and implementation strategies, and raise questions for further study. Because of the limited scope of these analyses, it is important to exercise restraint in drawing conclusions from study results; these reports are intended to provide preliminary analyses of complex issues and early insights into their nature and possible resolution.

The authors would like to extend sincere thanks to the many people who assisted with the completion of this project. Caroline Taplin, our project officer at the Office of the Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, provided strong leadership, guidance, and support through the paper's development. The federal interagency workgroup, put in place to guide the work of the task order contract, also played an integral role in setting the objectives for the study and providing feedback on all data collection instruments and drafts. Specifically, we want to extend our gratitude to Tanya Alteras, Steven Finan, Julia Paradise, Barbara Richards, Adelle Simmons, and Jennifer Tolbert at ASPE; Wendy Wolf, formerly of the Health Resources and Services Administration (HRSA); Karen Raykovich at HRSA; Cindy Shirk, formerly at the Centers for Medicare and Medicaid Services (CMS); and Christina Moylan, Angela Corbin, and Johanna Barraza-Cannon of CMS.

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Executive Summary

The Balanced Budget Act of 1997 established Title XXI in the Social Security Act, creating the State Children's Health Insurance Program (SCHIP). Title XXI provided states the authority and funding to expand health insurance coverage to low-income children by expanding Medicaid, developing new "separate" child health programs, or a combination of both approaches. During the first three years of SCHIP, considerable policy attention was directed at state efforts to enroll eligible children and, over time, states implemented numerous strategies to streamline the application process with the goal of achieving higher enrollment. As state SCHIP programs have matured, national enrollment has steadily increased—between the second quarters of federal fiscal year 1999 and 2000, enrollment grew by 90 percent (Rosenbach et al. 2001) More recently, the Centers for Medicare and Medicaid Services (CMS) reported that in federal fiscal year 2001, 4.6 million children participated in SCHIP. Still, even as states made headway in enrolling eligible children, anecdotal evidence emerged as early as mid-1999 that large proportions of SCHIP enrollees were losing eligibility, or disenrolling, at the end of their period of coverage. Early work by groups like the National Governors Association revealed that states had done little to streamline their eligibility renewal processes (compared to their efforts to simplify initial enrollment) and that the need to improve rates of retention was an important emerging challenge for the states.

Given policymakers' continued interest in enrolling eligible children into SCHIP and a more recent focus on improving retention rates in the program, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study of state efforts to enroll and retain children in SCHIP. Specifically, the Institute was asked to collect and analyze information about states' application and eligibility redetermination processes under SCHIP, as well as data on the outcomes of these processes. This report focuses on our findings related to retention; findings from our study of enrollment are examined in a companion report (Hill and Lutzky 2003).

Information and data were collected from eight states, selected based on a variety of demographic and programmatic variables, during the spring and summer of 2000. The states were queried on such issues as

- administrative responsibility for SCHIP eligibility redetermination;
- the process for notifying families of the need to renew SCHIP eligibility and how it differs from that of Medicaid;
- the procedures families must complete in establishing ongoing coverage under SCHIP and Medicaid;
- strategies used to facilitate eligibility renewal under SCHIP and Medicaid; and

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- the processes by which applications are denied and families are notified of this denial.

We also discussed the lessons state officials had learned through the operation of these systems about the barriers that persist for families renewing SCHIP coverage, and strategies for overcoming these barriers.

The second component of the study involved the collection and analysis of eligibility redetermination outcomes data. Specifically, we collected data on

- the number of SCHIP enrollees coming up for eligibility renewal and, of these, the number approved for SCHIP coverage, denied SCHIP coverage, and referred to Medicaid;
- the number of referrals to Medicaid that were approved, denied, or withdrawn;
- the number of eligibility denials that were due to "failure to meet eligibility criteria;"
- the number of eligibility denials that were due to "failure to comply with procedures;" and
- the number of cases that appeared to be "lost" from the system at the point of eligibility redetermination.

We typically found that states had a difficult time producing outcomes data, varied considerably in their data collection and reporting practices, and that no state could produce all of the measures of interest.

Findings and Implications for Future Policy

By collecting and analyzing information on the eligibility redetermination processes states use for SCHIP and Medicaid, as well as administrative data on the outcomes of these processes, we had hoped to make informed observations regarding how various policy strategies have affected rates of retention, approval, and denial of coverage in the sample of eight states. Because of limitations of state data systems and similarities in policies among our small sample, we were in most cases unable to draw such clear links.[1] However, we did learn a great deal about the procedures states follow in their redetermination efforts; the strengths and weaknesses of state systems; the rates at which children are approved and denied for ongoing eligibility under SCHIP; and the various reasons children lose eligibility at redetermination. The major findings of this study and their implications for future policy include the following:

- **States' procedures for conducting SCHIP eligibility redetermination are quite similar to one another. However, these processes have not undergone the same level of reform in the interest of simplification as have initial enrollment processes.** By and large, the eligibility redetermination processes in the study states were quite similar—all primarily relied on computer-generated notices, mailed to families between 60 and 90 days before the end of a child's

eligibility period, as the means for informing parents that their children's SCHIP eligibility needed to be renewed. Every state we studied sends reminder notices to families that do not respond to initial letters, but few consistently make more personal contact with these families either by phone or in person. And with the exception of one state—Florida—all of our study states disenroll children whose parents do not ever respond to redetermination notices.

In comparison to initial application procedures, much less attention appeared to have been paid to exploring strategies for simplifying or streamlining the SCHIP redetermination process. Although we identified states that were employing such strategies as simplifying the redetermination form, preprinting redetermination forms with information already on hand, and passively continuing children as enrollees even if their parents do not participate in redetermination, these efforts were used by a minority of states included in this study. Each of the participating states, however, identified the need to simplify redetermination as an emerging priority and speculated that future efforts would be focused on this issue.

- **Less than 50 percent of children appeared to be retaining SCHIP eligibility at redetermination. But further research is needed to understand what is reasonable to expect for this program.** In four of the five states that submitted comparable data, only between 26 and 48 percent of children up for renewal were approved for continued eligibility under SCHIP at redetermination. On the surface, these numbers seem low. Yet state officials pointed out that they are unclear as to what to expect with this population. For example, our findings suggest that a relatively large portion of children live in families whose incomes drop during their enrollment period in SCHIP, enough so that they are referred to Medicaid at redetermination. At the same time, we found that other children were denied because their parents' income had risen above upper income thresholds, or because they now possessed private insurance. All of these causes are appropriate grounds for terminating SCHIP eligibility and do not necessarily result in a child becoming uninsured.

  Families with children enrolled in SCHIP appear to live in dynamic circumstances that may see them move in and out of employment, and offered private insurance as an outgrowth of that employment. As such, retention rates for this population may inherently be somewhat low. It will be necessary for future research to monitor these dynamics more closely.[2]

- **High rates of parents who do not respond to renewal notices nor submit renewal applications for their children may be cause for concern.** Between 10 and 40 percent of all children were reportedly "lost" to the system at redetermination—that is, their parents never responded to renewal notices or submitted renewal applications. (This was the leading reason for denial in three of the five states that submitted comparable data.) While the potential reasons for such nonresponses are many—ranging from families whose addresses have changed and, thus, never received their notices, to families that have obtained private health insurance and thus no longer need SCHIP—there was a strong sense among state officials that a significant portion of "lost" cases may be families that don't reapply because they are confused about the rules and procedures they are to follow

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to keep their children's coverage up to date. This confusion may well grow from the computer-generated letters and notices that that were typically described as "not user-friendly" and "difficult" to understand. To the extent that this is true, it suggests that systems are insufficient to ensure that eligible children retain the coverage for which they are eligible, and that systems need to improve their ability to maintain current contact information and convey, in simple terms, the steps families must complete to renew their children's coverage. Once again, further research is needed to understand more precisely why a large number of families do not respond to renewal notices and reapply for their children.[3]

- **Denial of eligibility for "failure to pay premiums" may or may not address whether SCHIP cost sharing is affordable.** We were particularly interested in how many children lost eligibility because their parents failed to pay the premiums required by their state's SCHIP program, presuming that this would shed light on the question of whether premiums under SCHIP were affordable. As it turns out, our findings on this score were inconclusive. Instead, we learned that the denial code of "failure to pay premiums" could actually reflect a number of possible outcomes—that families moved out of state and, as a result, stopped paying their premiums; that families picked up insurance from their employers and, as a result, discontinued their SCHIP participation; that families were unsatisfied with their experiences with SCHIP coverage and chose to stop paying for it; or, indeed, that premiums were deemed unaffordable and thus families stopped sending them in.

- **State SCHIP and Medicaid data systems are highly variable in their capacity to report eligibility and redetermination outcome data.** One of the most important conclusions of this study is that state administrative data systems are unable to report precisely on the outcomes of the eligibility redetermination process. Even among states that could provide the data we requested, the codes, definitions, and classifications of various data elements were inconsistent across states, making aggregation and cross-state comparisons difficult, if not impossible.

  If states are to make informed improvements in their eligibility renewal policies, then they will need either to make investments to improve their administrative data systems, or periodically conduct disenrollee surveys, parent focus groups, or other research to better understand what happens to children once they lose their SCHIP eligibility. At the national level, policymakers should consider whether developing standardized approaches for collecting, compiling, and reporting SCHIP and Medicaid redetermination outcomes data might be beneficial.

Is There a Hole in the Bucket?
Understanding SCHIP Retention

Introduction and Background

The Balanced Budget Act of 1997 established Title XXI of the Social Security Act, creating the State Children's Health Insurance Program (SCHIP). Title XXI provided states the authority, as well as approximately $40 billion over ten years, to expand health insurance coverage to low-income children by expanding Medicaid, developing new "separate" children's health programs, or a combination of both approaches. During the first three years of SCHIP, considerable policy attention was directed at state efforts to enroll eligible children. As the SCHIP program has matured, enrollment has increased dramatically—between the second quarters of federal fiscal years (FFY) 1999 and 2000, enrollment grew by 90 percent (Rosenbach et al. 2001). More recently, the Centers for Medicare and Medicaid Services reported that in FFY 2001, 4.6 million children participated in SCHIP, an increase of 38 percent over the prior fiscal year (CMS 2002).

As states began making headway in addressing the challenge of improving enrollment, new challenges were appearing on the horizon—beginning in mid-1999, anecdotal evidence began to emerge from the states that large proportions of children enrolled in SCHIP appeared to be losing eligibility or disenrolling at the end of their period of coverage. That year, the National Governors Association (NGA) convened a small working meeting of state SCHIP officials to discuss the issue and to identify strategies that might simplify the eligibility redetermination process and improve children's retention in SCHIP and Medicaid. That meeting revealed that some states had just begun to explore and implement such strategies as using joint SCHIP/Medicaid redetermination forms, not requiring face-to-face interviews at redetermination, reducing verification requirements, and preprinting redetermination applications with information already on hand, thus making it easier for families to renew eligibility by simply updating personal information. At the conclusion of this meeting, though, it was also clear that maximizing retention in SCHIP was an emerging challenge for the states and that redetermination simplification strategies were not being as uniformly adopted by states as strategies to streamline initial enrollment (NGA Center for Best Practices 1999).

Since that time, state officials have begun to shift their focus to eligibility redetermination and strategies for maximizing retention of eligible SCHIP enrollees. As with the initial enrollment process, simplification at redetermination is likely an important step toward ensuring that eligible children have ongoing public health insurance coverage. Although simplifying initial enrollment procedures is important for encouraging families to apply, simplifying procedures at eligibility redetermination may be helpful in ensuring that eligible children are not inappropriately disenrolled, and that burdensome requirements do not discourage families from

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participating. New research indicates that a sizable subgroup of low-income uninsured children—18 percent—had been enrolled in Medicaid or SCHIP at some point in the preceding year. Thus, improving retention in Medicaid and SCHIP may contribute to reducing uninsurance among children (Kenney and Haley 2001). Moreover, for states with separate child health programs, coordinating eligibility redetermination between SCHIP and Medicaid is needed to provide seamless transfer of children from one program to another as families' income and circumstances change.

In light of policymakers' continued interest in enrolling eligible children into SCHIP and the more recent focus on improving retention rates in the program, the U.S. Department of Health and Human Services' Office of the Assistant Secretary for Planning and Evaluation (ASPE) asked the Urban Institute to conduct a study of state efforts to enroll and retain children in SCHIP. With the assistance of a federal interagency workgroup, it was decided that the Institute would identify and analyze SCHIP application and redetermination processes and the outcomes of these processes. This approach would not only identify and highlight state policy efforts to streamline enrollment and improve retention, but also provide a context for requesting state data that could shed light on the various outcomes of states' SCHIP enrollment and redetermination efforts. This report focuses on our findings related to retention; findings of our study on enrollment are examined in another companion report (Hill and Lutzky 2003).

By coupling redetermination process information and outcomes data, this study is intended to help federal and state policymakers better understand

- what is occurring when families attempt to renew SCHIP eligibility;
- what proportions of children are approved and denied eligibility at the point of eligibility redetermination;
- why applicants fail to retain coverage at redetermination; and
- what effects various simplification strategies have had on retention rates.

The remainder of this paper is organized into four sections. The first section describes the study's methodology, specifically elaborating on the way we selected our sample of eight states, collected information on eligibility redetermination processes, and collected state data on redetermination outcomes. We also discuss the limitations of these data and the difficulties we encountered in developing cross-state comparisons. The second section presents our findings related to SCHIP eligibility redetermination processes, focusing on state efforts to simplify these procedures and identifying the various process-related barriers to enrollment and retention that persist in the states. The third section reveals our findings related to SCHIP eligibility redetermination outcomes, presents data on states' rates of approval and denial, and identifies the reasons children appear to be denied eligibility at redetermination. The fourth and final section summarizes our conclusions and discusses the implications of our findings for future federal and state policy related to SCHIP retention.

Study Methods

During the spring and summer of 2000, we requested information and data from eight states, selected based on their diversity in size, population characteristics, geographic location, SCHIP program design, and ability to provide data on enrollment and eligibility redetermination outcomes. These states were Alabama, California, Colorado, Florida, Michigan, Missouri, New York, and North Carolina.

Among these eight states, only one—Missouri—implemented Title XXI solely through an expansion of Medicaid. The remaining seven created separate child health programs, either alone or in combination with Title XXI Medicaid expansions.

Collecting Information on Application and Eligibility Redetermination Processes

Information on state redetermination processes was collected through telephone interviews with state program officials. A standard protocol was used to ensure consistency across the interviews. First, we reviewed and confirmed background information on each state's SCHIP program characteristics, information already collected under the Urban Institute's SCHIP evaluation.[4] This included information related to the design of each state's SCHIP program, eligibility thresholds, implementation dates, and eligibility redetermination procedures. Next, we explored in detail how states' eligibility redetermination processes worked, and queried state officials on the following issues:

- How and when the program notifies families that their children are due for redetermination;
- The kind of forms used for eligibility redetermination, and how they differ from the initial application form;
- Documentation required from families for eligibility redetermination;
- The number of times the program attempts to remind families about their upcoming redetermination and the manner in which the reminders are made (i.e., whether by letter, postcard, phone call, in-person contact, etc.);
- What happens when an enrollee fails to participate in the redetermination process; and
- Strategies used to facilitate families' renewed retention of eligibility for children in SCHIP and Medicaid.

Finally, we discussed the lessons state officials had learned to date about the operation of these systems, barriers that persist for families renewing SCHIP coverage, and strategies for overcoming these barriers. This initial assessment provided us the context for requesting and interpreting redetermination outcome measures.

Collecting and Analyzing Redetermination Outcomes Data

The second component of the study involved the collection and analysis of eligibility redetermination outcomes data with which we hoped to answer the following research questions:

- What proportions of children are approved and denied SCHIP coverage at redetermination, and what portion are referred to Medicaid?
- What are the leading reasons children lose their eligibility at redetermination?
- What are the policy implications of these findings for both the design of eligibility redetermination processes, and the data systems that report the outcomes of these processes?

To answer these questions, a standardized set of outcome measures was requested of all states. We requested data for two points in time—May 1999 and May 2000. The data collected included

- the number of children that were processed for redetermination of SCHIP eligibility and, of these, the number continued, denied, and referred to Medicaid;
- the number of children referred to Medicaid that were approved, denied, or withdrawn;
- the number of redetermination denials that were because of "failure to meet eligibility criteria" (including such reasons as excess income, ineligible age, excess resources, insurance at time of application, dropped insurance within waiting period, and access to affordable insurance); and
- the number of redetermination denials that were because of "failure to comply with procedures" (including missing required verification of income resources, Social Security number, age/birth certification, residency, citizenship/immigration information, health insurance information), or failure to pay premiums/enrollment fees.

It is important to note that, across the board, states had a very difficult time producing outcomes data, that states varied considerably in their data collection and reporting practices, and that no state could produce all of the measures of interest. Through the data collection process, we identified the following limitations of state data systems:

- **Unavailability of Medicaid data.** While we set out to collect both SCHIP and Medicaid data, most states could only provide SCHIP data, and only one separate child health program was able to provide Medicaid data. Medicaid programs were largely unable to produce detailed information on redetermination outcomes because these data were often maintained by counties and not routinely aggregated at the state level.
- **Unavailability of SCHIP data from 1999.** While we had hoped to measure states' progress by observing data from both May 1999 and May 2000, most states were not able to provide specific point-in-time data for the earlier period given the newness of programs and systems. Thus, longitudinal comparisons were not possible.

- **Incomparable data across states.** Available state data were often reported inconsistently by states, with considerable variation in how they defined, classified, collected, and organized outcome measures. As a result, cross-state comparisons were difficult to make. Only five of the eight states were able to provide data on redetermination outcomes that were comparable to one another.
- **Inability to report on redetermination outcomes.** Three of the eight states in our study could not report data specific to the eligibility redetermination process. Rather, these states collected and reported data on "case closures," which also include children disenrolled at points other than redetermination. Thus, we were forced to consider these states separately in our analysis.

Despite these challenges, we were able to collect useable data; follow-up interviews with state officials helped us to better understand the nuances of the data states provided. These interviews were conducted in January/February 2001. Specifically, state officials helped us decide how to group various denial codes into broader categories for analysis, understand the limitations of their data systems in producing the outcome measures of interest, and interpret the data.

SCHIP Eligibility Redetermination Processes

This section discusses SCHIP eligibility redetermination processes in our eight states. In addition, it presents findings related to states' efforts to streamline these processes, potential barriers to retention, and the challenges of coordinating these processes with Medicaid.

Administrative Responsibility for Determining Eligibility

Under Medicaid, the federal statute requires that state or county government employees make determinations of eligibility for Title XIX. Under SCHIP, however, states establishing separate child health programs were extended flexibility to devise other arrangements for eligibility determination. We found, even among our small sample of states, considerable variation in the entities that maintained responsibility for this function:

- **State-level agencies.** Just one state used a state-level agency to process SCHIP applications and renewals; a significant departure from the traditional county-level departments of social services that have historically conducted Medicaid eligibility reviews. In Alabama, at the time of our study, the ALLKids program contracted with the State Employees Insurance Board (SEIB) to conduct its enrollment and redetermination processes, while the remainder of the program's administrative responsibilities lie with the Alabama Department of Health.[5]
- **Not-for-profit agencies and private vendors.** In four other states with separate programs, agencies or vendors outside of government have been made responsible for SCHIP eligibility determination and redetermination. In Florida, the not-for-profit Healthy Kids Corporation reviews all applications and renewals for the

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state's KidCare program. California's Managed Risk Medical Insurance Board contracts with EDS Corporation to review all applications for the Healthy Families/Medicaid for Children program. In Colorado, the CHP+ program contracts with Child Health Advocates for its outreach and eligibility determination functions, while Michigan contracts with the enrollment broker firm Maximus to carry out these functions.

- **Managed care plans.** In New York, responsibility for eligibility determination and redetermination in Child Health Plus resides with participating managed health care plans.[6]
- **County social services departments.** Two states rely on more traditional administrative arrangements for the intake and review of program applications. In both Missouri and North Carolina, county departments of social services, under the direction of the state Medicaid agency, conduct eligibility determination and redetermination for both the SCHIP and Medicaid programs.

SCHIP Eligibility Redetermination Processes and Efforts to Simplify

By and large, the eligibility redetermination processes in the study states were similar and included the following steps:

- States' computerized eligibility systems typically send out renewal notices and forms 60 to 90 days before the end of a child's enrollment period;[7]
- This initial contact is typically followed up by one or more reminder notices or postcards (few states make personal or telephone contact); and
- The enrollee either reapplies and eligibility redetermination is conducted, or the applicant fails to participate in the process and is subsequently disenrolled.

Our telephone survey also asked states about their efforts to streamline the redetermination process and potential barriers to keeping eligible children enrolled in SCHIP.

State Efforts to Simplify the Redetermination Process

Although the eight states in our study had only recently begun to focus on simplifying the redetermination process at the time of our survey, several strategies had already emerged. These are described below and summarized in table 1.

- **Simplifying the renewal form.** Among our sample of eight states, most had elected to use the same form for eligibility redetermination as they do for initial applications, with a cover letter detailing redetermination deadlines. However, two states—California and Missouri—had created more streamlined versions of their initial applications to use at redetermination.
- **Preprinting the renewal form.** Four of the study states—California, Florida, Michigan, and North Carolina—preprinted their renewal forms with some or all of the information collected from families during initial application. According to

Table 1. Redetermination Policies for Children in Separate Child Health SCHIP Programs and Medicaid, May 2000

State	SCHIP redetermination form				Face-to-face interview			Frequency (in months)	
	Joint form	Same as initial application	Streamlined[a]	Preprinted	SCHIP	MA	SCHIP verification	SCHIP	MA
AL	X	X				X	None	12	12
CA			X	X			Income	12	3[b]
CO	X	X					Income	12	12
FL				X			None	6	6; 12 for children under age 5
MI				X			Income	12	12
MO	NA		X				Income	NA	12
NC	X	X		X			Income	12	12
NY	X[c]	X				X	Income and residency	12	12
Total	**4**	**4**	**2**	**4**		**2**			

Sources: Cohen Ross and Cox (2000) and interviews with state officials.
NA = not applicable
a. Streamlined is defined as shorter than the initial eligibility application.
b. In January 2001, Medicaid implemented 12 months continuous coverage for children.
c. Medicaid is supposed to use the joint form for redetermination, but some forms still use a Medicaid-only recertification form.

state officials, preprinting forms can simplify the renewal process since families are only asked to update the eligibility information already on file.

- **Passive redetermination.** Florida is the only state in our sample to conduct passive redetermination—that is, rather than disenrolling a child whose family does not resubmit an SCHIP renewal form, Florida continues to consider the child enrolled. In this process, the state's data system produces a renewal form that includes the most recent information the state has about the family. Families are only required to return the application if there have been changes to this information. Florida reported that they typically receive responses indicating changes in 20 percent of all cases. State officials are comfortable with this approach, since the Healthy Kids program requires families to submit premiums each month as a condition of ongoing eligibility. Therefore, as long as a families' premiums are up to date, SCHIP officials assume that they are still residing in the state and interested in participating in the program.

- **Reduced documentation requirements.** Five of the eight states—California, Colorado, Michigan, Missouri, and North Carolina—only required the submission of income documentation at the point of renewal, deeming that self-declaration of changes in other eligibility criteria is sufficient. As with the application process, reducing documentation requirements at renewal reduces the possibility that families submit incomplete applications and, as a result, lose coverage for an otherwise avoidable reason.

Persistent Process-Related Barriers to Re-enrollment

While the states in our study had begun to implement strategies to streamline the SCHIP renewal process, there remained several process- and documentation-related barriers that appeared to affect the ability of children to retain their coverage. Notably, some of these barriers relate to inconsistencies between SCHIP and Medicaid policies that can complicate the smooth transition of a child from one program to the other if his or her income or family circumstances change. Specifically, state officials identified the following barriers to renewal that existed in their states.

- **Reliance on a mail-based system for contacting families.** As stated above, and perhaps for obvious reasons of efficiency, most states send families notices and/or postcards reminding them that their child(ren) needs to renew his or her eligibility. Still, state officials speculated that following up with phone calls or in-person reminders might yield better response rates. County offices in North Carolina follow up with personal phone calls to remind families about their redetermination deadline. In New York, The Bronx Health Plan (a plan participating in Child Health Plus) makes door-to-door visits to remind families, and both states believe that these efforts help stimulate families to renew coverage.

- **Resubmission of documentation.** While all eight states have families' information on file, only four preprinted that information on their renewal forms, and all but Florida required the submission of income documentation. Moreover, New York required the resubmission of income and residency documentation. State officials generally agreed that these practices increase the "hassle factor" associ-

ated with eligibility renewal and might keep a family from promptly completing their applications.

- **Potential confusion over requirements to continue enrollment.** Some state officials noted that their redetermination procedures may cause significant confusion among families. For example, most states described their computer-generated renewal notices as complicated and "not user-friendly." They believed it was entirely possible that families could be confused by the content of these notices and not understand what actions they needed to take. In another interesting instance, Colorado found that preprinting its renewal form actually led to more problems with retention; the state pilot-tested a preprinted form in Denver and found that fewer enrollees participated in the redetermination process after the change than before the pilot. State officials speculated that, by preprinting the form, families may have assumed that the state already had their information on file and, therefore, they didn't need to take any action to renew their children's eligibility.

- **Inconsistent rules and procedures for SCHIP and Medicaid redetermination.** As was found to be the case with initial eligibility (Hill and Lutzky 2003), states' SCHIP and Medicaid eligibility redetermination rules and procedures are also often out of sync. Some of the inconsistencies with the redetermination processes of the two programs are: only four of the eight programs in our study used a joint redetermination form; New York and Alabama still required face-to-face interviews for children re-applying for Medicaid but not for enrollees re-applying for SCHIP; and at the time of our data collection, California conducted redetermination for SCHIP enrollees at the 12th month of eligibility, while Medicaid redetermination was conducted every three months.[8] Alabama also witnessed confusion among families with enrolled children when it used a simplified redetermination form, then switched to a longer form that included Medicaid eligibility screening questions. Alabama found that using a streamlined SCHIP redetermination form didn't make sense because so many of its enrollees were Medicaid-eligible at redetermination and the Medicaid program was unable to accept the SCHIP referrals without requiring families to take additional follow-up steps.

  To the extent that rules and procedures for renewal do not match for SCHIP and Medicaid, families must often take different and/or additional steps to complete the process if changes in income or family circumstances require that their children be moved from one program to the other. State officials consistently reported that this could create additional administrative barriers to smooth continuation of coverage.

- **Automatic disenrollment for lack of response.** As stated above, all of the states in our sample, with the exception of Florida, automatically disenroll children whose parents do not complete the redetermination process. State officials speculated that many families might be unclear about what's required of them at renewal, and thus wondered whether it would be wise to permit nonresponding families a "grace period" during which coverage could be maintained and state

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and/or local officials could follow up with families and attempt to renew their children's coverage.

SCHIP Redetermination Outcomes

In addition to qualitative information, we collected administrative data from the study states on the outcomes of their redetermination processes. Specifically, we collected data on the numbers of SCHIP renewals that were processed, approved, or denied for continued SCHIP coverage or referred to Medicaid. For this study, we defined eligibility "denials" as including those children whose parents did not respond to renewal notices or submit renewal applications. Of those denied continued eligibility, we gathered data on the reasons why children were denied coverage at redetermination. By coupling our analysis of administrative data with the qualitative information on states' redetermination procedures, we hoped to gain a better understanding of the effects of various policies and procedures on the outcomes of these procedures. As described in the study methods section, however, the data collection effort was challenging and inconsistent system designs and reporting structures among the states made neat comparisons difficult.[9] These findings are summarized below.

Rates of Approval, Denial, and Referral to Medicaid at Redetermination

In analyzing states' data on eligibility redetermination outcomes, we found that not all states' data were comparable. Specifically, we learned that five states could report with fair precision on the various outcomes of their eligibility redetermination processes (i.e., how many redeterminations were processed, and how many were approved, denied, and referred to Medicaid). These states were Alabama, Colorado, Michigan, North Carolina, and New York. However, three of the study states—California, Florida, and Missouri—did not collect or report data specific to eligibility redetermination. Rather, these states maintain broader files on monthly "case closures," which include denials that occur at redetermination as well as denials that occur at points other than redetermination. Therefore, as the nature of these two types of data sets were inconsistent, we present and discuss the findings from these two groups of states separately in the analysis that follows.

Table 2 presents the outcomes of the SCHIP redetermination processes in the study states. Specifically, among the five states reporting comparable data, we found

- Approval rates for continued SCHIP eligibility at redetermination ranged from 65 percent in New York to 26 percent in Michigan. In between these two extremes, Alabama, Colorado, and North Carolina reported approval rates within 13 percentage points of one another, in the range of 35 to 48 percent.
- Rates of SCHIP denial at redetermination clustered in a fairly tight range among the five states with comparable data, ranging from 51 percent in Colorado to

Table 2. SCHIP Redetermination Rates of Approval, Denial, and Referral to Medicaid, May 2000

State	Number processed	Percent approved	Percent denied	Percent referred to Medicaid
Alabama	1,132	48	36	17
Colorado	1,715	39	51	9
Michigan	537[a]	26	42	32
North Carolina	3,821	35	50	14
New York	84,463[b]	65	35	—[c]
States reporting case closure data[d]				
California	—	—	—	—
Florida	—	—	—	—
Missouri	—	—	—	NA

Source: data collected for this report.
— = data not available or not collected
NA = not applicable
a. Total number of redetermination applications processed; applications may include more than one child.
b. Data provided are for first quarter, 2000.
c. In New York, health plans responsible for conducting SCHIP eligibility redetermination could not report data on referrals to Medicaid.
d. California, Florida, and Missouri do not automatically collect/report data at redetermination. Rather, monthly data on "case closures" are collected. In Florida, state officials estimate that overall retention rate is roughly 75 percent.

35 percent in New York. North Carolina, Michigan, and Alabama reported denial rates at redetermination of 50, 42, and 36 percent, respectively.

- The proportion of SCHIP applications that were referred to Medicaid as a result of screen and enroll at redetermination ranged from 32 percent in Michigan to 9 percent in Colorado. In between, rates of referral to Medicaid were reported in 14 percent of redeterminations in North Carolina and 17 percent in Alabama. New York could not report referrals to Medicaid at redetermination, due to the data collection and referral practices of health plans.
- Because they didn't collect data specific to redeterminations at the time of our study, no data are reported for California, Florida, and Missouri in table 2.

Once again, it is challenging to attempt to link state-to-state variations in the above rates to the particular eligibility redetermination policies and practices of the states. As was reported in the previous section, states' redetermination approaches are fairly similar, and in the cases where they are not, findings actually move in a direction opposite of what might be expected. For example, while Alabama requires submission of verification of income and other changes in the household at redetermination, Colorado only requires the submission of income verification. Yet Alabama's rate of approval is higher than Colorado's. Similarly, while Michigan and North Carolina preprint their redetermination applications with information already

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in the state's data systems, they report the two lowest approval rates among the five states with comparable data. Unfortunately, the state with arguably the most streamlined redetermination procedures—Florida, which uses preprinted forms and passively continues the enrollment of families that do not respond to state renewal notices—could not provide data specific to that process at the time of our study. We can, however, hypothesize that the rate of approval in New York is artificially high—the state could not report referrals to Medicaid at redetermination, and thus "approvals" likely include some proportion of children who appeared Medicaid-eligible to the reviewing health plans, but were maintained as Child Health Plus enrollees in these plans while the state followed up to see if they were Medicaid-eligible.

Overall, it is noteworthy that in four of the five states with comparable data, less than half of the children up for renewal of SCHIP eligibility were approved for continued coverage. In turn, between one-third and one-half of children were denied eligibility at redetermination in all five states. These findings are consistent with those of a study conducted after this one, where redetermination was found to generate disenrollment by roughly one-half of enrolled children in three states (Dick et al. 2002). Screen and enroll efforts appear to occur at redetermination, as four of the five states reported referrals to Medicaid of between 9 and 32 percent of all cases processed. In contrast to the situation with initial applications (Hill and Lutzky 2003), however, no state could report with certainty what the outcomes were of these referrals to Medicaid. Therefore, it is impossible to know from these data the total proportion of children that retained public coverage—either SCHIP or Medicaid—at the conclusion of the redetermination process.

These findings suggest that considerable turnover is occurring at SCHIP redetermination and that large proportions of children are losing SCHIP eligibility for one reason or another.

Reasons for Denial at Redetermination

We divided state data on the reasons why children were denied eligibility at SCHIP redetermination into three broad categories: those denied because they no longer met the SCHIP program's eligibility criteria; those denied because their parents failed to comply with redetermination procedures; and those who were "lost" to the system (i.e., were disenrolled because their parents never responded to renewal notices nor submitted renewal applications). We considered this latter group separately, as it became clear during our analysis that each state was seeing fairly large proportions of denials among children whose families never responded to states' notices informing them that their children's eligibility needed to be renewed, either because they never received them or because they chose not to respond to the notices for some reason. Results of our analysis are summarized below.

In table 3, we report states' data on the reasons children were denied eligibility at redetermination. In the upper half of the table, the five states with comparable data specific to redetermination outcomes are presented. In the lower half, we present the data from the three states that shared more general "case closure" data on SCHIP enrollees.

Table 3. Reasons for Denial of SCHIP Eligibility at Redetermination, May 2000

State	Number processed	Percent denied	Percent denied for failure to meet eligibility criteria	Percent denied for failure to comply with procedures	Percent lost at redetermination
Alabama	1,132	36	13	2	21
Colorado	1,715	51	10	17	25
Michigan	537[a]	42	23	9	9[b]
North Carolina	3,821	50	7	3	40
New York	84,463[c]	35	1	24	11
States reporting case closure data					
		Total closures			
California		6,009	26	47	27
Florida		13,214	36	64	—[d]
Missouri		1,946	61[e]	36	3

Source: Data collected for this report.

— = data not available or not collected

a. In Michigan, 225 refers to the total number of applications denied at redetermination; applications may include more than one child.

b. In Michigan, "incomplete applications" and "failed to return application packet" are folded together in a single code. Based on the advice of state officials, these denials were evenly divided between "failure to comply with procedures" (i.e., incompletes), and "lost at redetermination" (i.e., failed to return application packet) for this analysis.

c. Data provided are for first quarter, 2000.

d. Florida does not collect/report data at redetermination. Rather, data are "case closures" in May 2000. As such, the state cannot report "lost at redetermination."

e. Missouri found 1,422 children denied for SCHIP were Medicaid-eligible.

- Fairly low proportions of all children appear to be losing eligibility because they no longer meet SCHIP's eligibility criteria. Rates of denial for this reason ranged from 23 percent in Michigan to 1 percent in New York.
- The proportions of children who lost eligibility because their parents "failed to comply with procedures" fell within a similar range, from 24 percent in New York to 2 percent in Alabama.
- It is particularly noteworthy, however, that the largest proportion of denials in three of the five states with comparable data were children who were "lost" at redetermination. That is, between 9 percent (in Michigan) and 40 percent (in North Carolina) of all children lost eligibility at redetermination because their parents never responded to state notices informing them of the need to renew their children's coverage.

In the three states that reported data on broader reasons for case closures, significant variation was also seen state to state. For example, rates of case closure for children who no longer met eligibility criteria ranged from 61 percent in Missouri to 26 percent in California; rates of case closure for failure to comply with procedures ranged from 64 percent in Florida to 36 percent in Missouri; and children

who lost eligibility because their parents "did not respond to notices" for eligibility renewal were just 3 percent in Missouri, but 27 percent in California.[10]

Given the general similarities in most states' SCHIP redetermination procedures, it is very difficult to explain the significant variations among the states' reasons for denial data. In the next two sections, however, we take a closer look at each of the three reason categories and attempt to link the data to the characteristics of state policies and procedures.

Failure to Meet Eligibility Criteria

As is the case with initial applications, children can be denied eligibility at redetermination for no longer meeting one or more of their state's eligibility criteria under SCHIP. For example, parental income may increase above eligible limits, children may "age out" of the program by turning 19, or children may have obtained other health insurance. Our analysis found that, among the five states with comparable data, there was again considerable variation in the specific reasons children were found ineligible as a result of not meeting programs' eligibility criteria, and no single reason consistently emerged as the leading cause of denials. Table 4 details the following:

- Family income exceeding the state's SCHIP upper income threshold was the leading reason for children being denied in just one state—Michigan—accounting for 10 percent of all redetermination outcomes. Having income that was too high accounted for just 2 percent of redetermination outcomes in Alabama and North Carolina.
- Being over the age limit was the leading reason for criteria-related denials at redetermination in two states—Alabama and California—accounting for 4 and 7 percent of all redetermination outcomes, respectively.
- Larger numbers of children were denied continued eligibility at redetermination in Michigan and North Carolina because they were either found to be eligible for, or already enrolled in, Medicaid.
- Having other insurance at redetermination accounted for no more than 2 percent of redetermination outcomes in any of the study states.

Failure to Comply with Procedures

Children can also be denied continued SCHIP eligibility at redetermination if their parents fail to successfully complete the redetermination process. Such "procedural denials" can take many forms but, according to the data submitted for this study, they typically represent families that failed to submit a complete application (i.e., applications that were missing some or all of the documentation required to re-establish their child's eligibility), or families that had failed to keep their premium payments up to date—a condition required to maintain ongoing eligibility. These results are described in detail below, and are displayed in table 5.

Table 4. SCHIP Redetermination Denials for Failure to Meet Eligibility Criteria, by Reason, May 2000

State	Number processed	Percent denied due to eligibility criteria	Reason for denial (percent)								
			Found Medicaid-eligible	Excess income	Over age limit	Had insurance	Immigrant	Moved	Voluntary withdrawal	Already on Medicaid	Other
Alabama	1,132	13	1	2	4	2	—	2	2	—	—
Colorado	1,715	10	—	—	7	0	—	—	0	—	2[a]
Michigan	537	23	—	10	1	2	0	—	—	10	—
North Carolina	3,821	7	3	2	0	0	—	0	0	—	1[b]
New York	84,463	1	—	—	0	1	—	—	—	—	—
States reporting case closure data											
California	6,009	26	—	1	6	—	—	—	8	2	9[c]
Florida	13,214	36	—	25	—	—	—	—	1	—	9[d]
Missouri	1,946	61	NA	4	15	12	—	3	6	NA	22[e]

Source: Data collected for this report.

— = data not available or not collected

NA = not applicable

a. In Colorado, "other" represents denials because the child/family had excess resources.

b. In North Carolina, "other" represents denials for "unknown reasons."

c. In California, "other" represents children in families whose income was too low to qualify for continued SCHIP coverage (i.e., families were income-ineligible for Medi-Cal at redetermination), but who chose not to be referred to Medi-Cal.

d. In Florida, "other" represents denials due to changes in household composition.

e. In Missouri, "other" represents various reasons for denial, including "no longer meets eligibility criteria," "refused employment," etc.

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Table 5. SCHIP Redetermination Denials due to Failure to Comply with Procedures, by Reason, May 2000

States	Number processed	Percent denied due to procedures	Reason for denial (percent)		
			Missing verification/ incomplete	Failed to pay premium	Other
Alabama	1,132	2	--	2	—
Colorado	1,715	17	6	—	10[a]
Michigan	537	9	9	—	—
North Carolina	3,821	3	3	0	—
New York	84,463	24	16	0	7[b]
States reporting case closure data					
California	6,009	47	12	32	3[c]
Florida	13,214	64	—	64	—
Missouri	1,946	36	30	6	—

Source: Data collected for this report.
— = data not available or not collected
a. In Colorado, "other" represent denials for unspecified reasons.
b. In New York, "other" represents denials for unspecified reasons.
c. In California, "other" represents denials for families that did not submit immigration status verification.

- Among four of the five states submitting comparable data, the submission of an incomplete application was the leading procedural-related reason for denial at redetermination. Denials for this cause ranged from 16 percent of all redetermination outcomes in New York, to 3 percent in North Carolina. (Alabama could not report data for this measure.)
- Denials of continued eligibility for failure to pay required premiums were much rarer, accounting for 2 percent or less of all redetermination outcomes in the study states.
- The fact that relatively high proportions of children were denied eligibility at redetermination for unspecified "other" reasons in Colorado and New York is potentially troubling; data systems in these states simply could not reveal the specific factors that were causing these families to lose eligibility under SCHIP.

"Lost" at Redetermination

Considerable doubt surrounds the actual make-up of the "lost" category. Based on our discussion with state officials, some of these cases are likely families that never received their redetermination notices (perhaps because they moved) and thus did not respond. In other cases, these denials might represent families that did receive their notices, but did not reapply on behalf of their children for one reason or another. In such a situation, the active decision by a family not to reapply could reflect reasons that a policymaker might consider "good" (for example, parents may have obtained a new job that provided dependent coverage and, therefore, they no longer needed SCHIP for their children), or for reasons that would be considered

"bad" (for example, they were confused by the notice and did not understand what they needed to do to reapply, or were unsatisfied with the coverage that SCHIP provided their children, or found the program's premiums unaffordable). Unfortunately, from the administrative data alone, it appears that state officials have no way of knowing precisely what has transpired for these families.[11]

Conclusions and Implications for Future Policy

This study documented the SCHIP eligibility redetermination processes used in a sample of states, and also collected and analyzed state administrative data on the outcomes of those processes. By combining the study's qualitative and quantitative findings, we hoped to make informed observations regarding how various policies and program strategies appeared to affect retention under SCHIP, as well as gain insights into the reasons children are denied eligibility at application and redetermination and how various policies may be influencing these outcomes. Furthermore, we hoped to learn more about the data systems states use to report on SCHIP redetermination outcomes and identify the strengths and limitations of those systems.

With this study now complete, we can conclude that we were able to achieve many, but not all, of these goals. Through telephone interviews with states, we were able to learn a great deal about the procedures states follow in requesting, accepting, and reviewing SCHIP renewal applications. We were also able to collect much useful data from the states. While this effort was challenging, it did permit us to learn about the strengths and weaknesses of SCHIP eligibility data systems, and the inconsistencies in these systems from state to state. In most instances, however, we were not able to draw clear links between the redetermination policies states use and the effects these policies have on retention outcomes. In the small sample of states we worked with, states' policies and approaches to eligibility redetermination were more similar than not. As such, it was often difficult to interpret the findings in any given state and hypothesize whether differences between the states were due to particular policies they had adopted.

This section summarizes the major findings of the study and discusses the implications of these finding for future policy and program design.

- **States' procedures for conducting SCHIP eligibility redetermination are quite similar to one another. However, these processes have not undergone the same level of reform in the interest of simplification as have initial enrollment processes.** By and large, the eligibility redetermination processes in the study states were quite similar—all primarily relied on computer-generated notices, mailed to families between 60 and 90 days before the end of a child's eligibility period, as the means for informing parents that their children's SCHIP eligibility needed to be renewed. Every state we studied sends reminder notices to families that do not respond to initial letters, but few consistently make more personal contact with these families either by phone or in person. And with the

exception of Florida all of our study states disenroll children whose parents do not respond to redetermination notices.

Interestingly, in comparison to initial application procedures (Hill and Lutzky 2003), much less attention appears to have been paid, to date, to exploring strategies for simplifying or streamlining the SCHIP redetermination process. Although we identified states that were employing such strategies as simplifying the redetermination form, preprinting redetermination forms with information already on hand, and passively continuing children as enrollees even if their parents do not participate in redetermination, these efforts were used by a minority of the states in this study. Each of the participating states did, however, identify the need to simplify redetermination as an emerging priority and speculated that future efforts would be focused on this issue.

- **Less than 50 percent of children appear to be retaining SCHIP eligibility at redetermination. But further research is needed to understand what is reasonable to expect for this program.** For four of the five states submitting comparable data, only between 26 and 48 percent of children up for renewal were approved for continued eligibility under SCHIP at redetermination. On the surface, these numbers seem low. Yet state officials pointed out that they are unclear as to what to expect with this population. For example, our findings suggest that a relatively large portion of children live in families whose incomes drop during their enrollment period in SCHIP, enough so that they are referred to Medicaid at redetermination. At the same time, we found that other children were denied because their parents' income had risen above upper income thresholds, or because they now possessed private insurance. All of these causes are appropriate grounds for terminating SCHIP eligibility and do not necessarily result in a child becoming uninsured.

  One conclusion that can be drawn from these findings is that families with children enrolled in SCHIP live in dynamic circumstances that may see them move in and out of employment, and which may see them offered private insurance as an outgrowth of that employment. As such, retention rates for this population may inherently be somewhat low. It will be necessary for future research to monitor these dynamics more closely.

- **High rates of parents who fail to respond to renewal notices or submit renewal applications for their children are cause for concern.** Between 10 and 40 percent of all children were reportedly "lost" to the system at redetermination—that is, their parents never responded to renewal notices nor submitted renewal applications. (This was the leading reason for denial in three of the five states that submitted comparable data.) Based on our conversations with state officials, some of these "lost" cases are likely families that have moved and, thus, contact information for them is no longer current. Others, according to informal surveys of disenrollees, appear to be families that have obtained private coverage and no longer need SCHIP. However, these officials also believe that a significant portion of "lost" cases may be families that don't reapply because they are confused about the rules and procedures they need to follow to keep their children's coverage up to date. This confusion may well result from the computer-

generated letters and notices that are sent by states to inform families that their children's eligibility is up for renewal, letters and notices that were generally described by state officials as "not user-friendly" and "potentially difficult" to understand. To the extent that this is true, this finding suggests that current systems are insufficient to ensure that eligible children retain the coverage to which they are arguably entitled.

States may need to explore strategies for routinely updating contact information for enrolled children and their families. This is perhaps especially needed in light of the fact that a majority of states have instituted 12-month continuous coverage, and the likelihood that significant numbers of families may change residences during this extended eligibility period may be high. Just as important, however, is the notion that states may need to re-examine their procedures for notifying families of the need to renew SCHIP eligibility, and revise their notices and letters to make them clearer and more user-friendly. States may wish to consider adopting strategies that allow for more direct, personal contact with families that have not responded to initial notices. Finally, our discussions with state officials suggest that periodic surveys of disenrollees may be a helpful way of monitoring the reasons children drop off SCHIP and Medicaid and where they go after disenrolling, and of gaining a clearer understanding of issues left unexplained by administrative data.

- **Denial of eligibility for "failure to pay premiums" may or may not address whether SCHIP cost sharing is affordable.** In analyzing the various reasons that children are denied eligibility at redetermination, we were particularly interested in how many had their cases closed because their parents had failed to pay program premiums. The rate of such denials, we presumed, would shed light on the question of whether premiums under SCHIP were affordable for families. As it turns out, our findings were inconclusive regarding the proportion of families that actually lose eligibility for this reason.

  More important, however, we learned through our discussions with state officials that a denial coded as "failure to pay premium" cannot simply be interpreted as a reflection of the affordability of those premiums. Rather, state officials clarified that such denials were actually reflective of a number of possible outcomes: that families moved out of state and, as a result, stopped paying their premiums; that families now received insurance from their employers and, as a result, discontinued their SCHIP participation; that families were unsatisfied with their experiences with SCHIP coverage and chose to stop paying for it; or, indeed, that premiums were deemed unaffordable and thus families stopped sending them in.

- **State SCHIP and Medicaid data systems are highly variable in their capacity to report redetermination outcome data.** Perhaps one of the most important conclusions to be drawn from this study is that state administrative data systems are unable to precisely report on the outcomes of eligibility and redetermination processes. While we found this to be true of both SCHIP and Medicaid systems, Medicaid systems in particular, due to their age and complexity, were reported as largely incapable of producing the outcome measures of interest. At

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one extreme, a number of states that we initially approached for participation in the effort—including Indiana, Mississippi, and Pennsylvania, among others—ultimately could not participate because their data systems were unable to report the data we sought. (Most often, this was due to the fact that data were collected and compiled at the county level and aggregation at the state level was difficult or impossible.) However, even among those states that could provide data, the codes, definitions and classifications of various data elements were very inconsistent across states which made aggregation of data and cross-state comparisons very difficult, if not impossible.

If states are to make informed improvements in their eligibility renewal policies, then they will need to either make investments to improve their administrative data systems, or periodically conduct disenrollee surveys, parent focus groups, or other research to better understand what happens to children once they lose their SCHIP eligibility. At the national level, policymakers should consider whether developing standardized approaches for collecting, compiling, and reporting SCHIP and Medicaid redetermination outcomes data might be beneficial. Perhaps state administrators, working with their federal counterparts, could discuss alternatives for optimal data collection and reporting of data through various national forums in place for SCHIP and Medicaid research and policy analysis.

This study provides a detailed look into the policies and procedures states use to renew SCHIP and Medicaid eligibility for children, as well as the outcomes of these processes as reflected by state administrative data. It is hoped that the insights gained here can help inform future, more in-depth evaluation efforts, as well as contribute to the dynamic and evolving efforts at the federal and state level to improve the effectiveness of SCHIP programs.

Notes

1. For further information on the effects of alternative state policies on SCHIP disenrollment, see Dick et al. (2002).
2. Two recently published studies shed further light on these issues. See Dick et al. (2002) and Riley et al. (2002).
3. Riley et al. found evidence that states may be overestimating the number of children whose coverage inappropriately "lapses."
4. The Urban Institute SCHIP Evaluation is primarily funded by the Robert Wood Johnson Foundation and The David and Lucile Packard Foundation.
5. In 2001, the enrollment function for ALLKids was transferred to the Department of Health.
6. In 2001, New York rolled out its new Facilitated Enrollment initiative whereby a broader range of community based organizations, including managed care organizations, were authorized to conduct SCHIP eligibility determinations and renewals.
7. In Missouri, the computer system notifies the worker that a family is due for redetermination but does not send a notice to the family. The worker chooses when to begin the review process and then notifies the family. The children remain enrolled until they are determined to be ineligible.
8. California revised its process in 2001 to allow for 12 months of eligibility in Medicaid to improve consistency between the programs.
9. For further information on the effects of alternative state policies on SCHIP disenrollment, see Dick et al. (2002).
10. Florida could not report data for this measure.
11. In a study performed after this one, Riley and others conducted surveys and focus groups of parents whose children "lapsed" out of SCHIP (defined as those children who were disenrolled because their parents failed to complete the renewal process or did not pay their premium payments), and found that roughly two-thirds of parents perceived that their children were no longer eligible for SCHIP because they had found private insurance, had an increase in household income, or no longer qualified for some other reason. Furthermore, research by Dick and others suggests that disenrollment among at least a portion of these children is not intentional; in three states studied, roughly 25 percent of disenrolled children were found to have re-enrolled in SCHIP within two months.

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